



REQUEST FOR EMPLOYMENT INFORMATION IN CONNECTION WITH CLAIM FOR DISABILITY BENEFITS

SECTION I - IDENTIFICATION INFORMATION *(To be completed by VA)*

1. NAME AND ADDRESS OF EMPLOYER OF VETERAN <i>(Complete)</i>	RETURN TO	2. ADDRESS <i>(Complete)</i>
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INSTRUCTIONS: The veteran named in Item 3 has filed a claim for veterans disability benefits and has stated that he/she was recently employed by you. In order to arrive at a fair decision in this case, we need the information requested below. Please complete Sections II and III and return to this office at the above address. Please be sure to sign and date this form in Items 21A and 21B. **FOR FREE HELP IN COMPLETING THIS FORM, CALL VA TOLL-FREE: 1-800-827-1000 (TDD 1-800-829-4833).**

3. FIRST NAME - MIDDLE INITIAL - LAST NAME OF VETERAN	4. SOCIAL SECURITY NO.	5. VA FILE NO.
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SECTION II - EMPLOYMENT INFORMATION *(To be completed by employer)*

6. BEGINNING DATE OF EMPLOYMENT	7. ENDING DATE OF EMPLOYMENT	8. AMOUNT EARNED DURING 12 MONTHS PRECEDING LAST DATE OF EMPLOYMENT (BEFORE DEDUCTIONS) \$	9. TIME LOST DURING 12 MONTHS PRECEDING LAST DATE OF EMPLOYMENT (DUE TO DISABILITY)
10. TYPE OF WORK PERFORMED		11. NUMBER OF HOURS WORKED	
		A. DAILY	B. WEEKLY

12. CONCESSIONS (IF ANY) MADE TO EMPLOYEE BY REASON OF AGE OR DISABILITY		
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13A. IF VETERAN IS NOT WORKING, STATE REASON FOR TERMINATION OF EMPLOYMENT. IF RETIRED ON DISABILITY, PLEASE SPECIFY	13B. DATE LAST WORKED	14A. DATE OF LAST PAYMENT
		14B. GROSS AMOUNT OF LAST PAYMENT \$
15A. WAS LUMP SUM PAYMENT MADE? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "Yes," complete Items 15B and 15C)</i>	15B. GROSS AMOUNT PAID	15C. DATE PAID

SECTION III - INFORMATION ON BENEFIT ENTITLEMENT AND/OR PAYMENTS *(To be completed by employer)*

16. IS VETERAN RECEIVING OR ENTITLED TO RECEIVE, AS A RESULT OF HIS/HER EMPLOYMENT WITH YOU, SICK, RETIREMENT OR OTHER BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "Yes," complete Items 17 and 20)</i>	17. TYPE OF BENEFIT		
18. GROSS MONTHLY AMOUNT OF BENEFIT	19A. DATE BENEFIT BEGAN	19B. DATE FIRST PAYMENT ISSUED	20. DATE BENEFIT WILL STOP <i>(If known)</i>
21A. SIGNATURE OF EMPLOYER OR SUPERVISOR			21B. DATE

PRIVACY ACT INFORMATION: Collection of this information is authorized by law (38 U.S.C. 1521) and 38 CFR, Section 4.16 While you are not required to respond, your cooperation in providing this relevant and necessary information will help us determine the veteran's maximum benefit entitlement under the law. The responses you submit are considered confidential (38 U.S.C. 5701). They may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation Records -VA, published in the Federal Register. Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.